DOR 22-02

RECEIVED
AUG 12 2021
CERTIFICATE OF NEED PROGRAM
DEPARTMENT OF HEALTH

Certificate of Need
Determination of Reviewability
Ambulatory Surgical Facility and Ambulatory Surgery Center
(Do not use this form for any other type of ASC/F project)

Certificate of Need submissions must include a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

The Department of Health (department) will use this form to determine whether my ambulatory surgical center or facility requires a Certificate of Need under state law and rules. Criteria and consideration used to make the required determinations are Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310. I certify that the statements in the submissions are correct to the best of my knowledge and belief. I understand that any misrepresentation, misleading statements, evasion, or suppression of material fact in this application may be used to take actions identified in WAC 246-310-500.

My signature authorizes the department to verify any responses provided. The department will use such information as appropriate to further program purposes. The department may disclose this information when requested by a third party to the extent allowed by law.

Owner/Operator Name of the surgical facility as it appears on the UBI/Master Business License Aesthetic Rejuvenation Spa	
Clinical Practice UBI #: 603-043-327 Surgery Center UBI #: 603-043-327	Federal Tax ID (FEIN) # 47-3018148
Mailing Address 14212 Ambaum Blvd SW, Suite 304 Burien, WA 98166	Surgery Center Address 14212 Ambaum Blvd SW, Suite 304 Burien, WA 98166
Website Address: AR by DrBrecht.com	
Phone number (10-digit): 206-444-5014	Email Address: tinabrechtmd@hotmail.com
Name and Title of Responsible Officer (Print): Kristine Brecht, MD CEO/President	Signature of Responsible Officer: K Brecht Date of Signature: 8-6-21

Identify the purpose of your request:

- ☐ New Facility
- ☐ Change of Ownership
- ☐ Facility Relocation
- ☐ Facility Expansion – Operating Room Increase
- ☐ Facility Expansion – Service Increase
- ☒ Other (please provide a letter describing)

Applying to be ambulatory surgery center / DOH says I should be one.

N/A

Existing Facility Status

Complete for all applications concerning existing facilities

1. The CN Program previously determined the facility was not subject to CN Review (if yes, attach DOR letter)

   ☐ Yes ☒ No

2. If this request is for a change in ownership provide the following information:

Current facility's name	
Current facility's address	
Current facility's license number	ASF.FS.
Current facility's Certificate of Need status ?	☒ Exempt DOR# ____
	☐ Approved CN# ____
Anticipated change of ownership month and year	

3. If this request is for the relocation of an existing facility, provide the following information:

Current facility's address	
Anticipated relocation month and year	

Facility Information

4. Although you are not required to apply for an ASF license before a CN determination is issued, have you or do you intend to, apply for a license?*

   ☐ Yes, intend to apply ☐ No

   ☒ Yes, here is the facility's license #ASF.FS. 61210042

   *Your answer to this question will allow the CN program to effectively coordinate the licensure process with other DOH offices.

5.

Number of existing operating and procedure rooms:	1
Number of new operating and procedure rooms:	Ø
Total:	1

For Certificate of Need purposes operating and procedure rooms are one in the same.

Clinical and Surgical Services

6. Check all surgical procedures currently performed in the facility.

☐	Ear, Nose, & Throat	☐	Gynecology	☐	Oral Surgery
☒	Plastic Surgery	☐	Gastroenterology	☐	Maxillo facial
☐	Orthopedics	☐	Podiatry	☐	General Surgery
☐	Ophthalmology	☐	Pain Management	☐	Urology

☒ Other (describe) Aesthetic medicine / Nonsurgical

☐ This is a new facility, no surgical procedures are currently performed

Check all new surgical procedures proposed to be performed in the facility

☐	Ear, Nose, & Throat	☐	Gynecology	☐	Oral Surgery
☐	Plastic Surgery	☐	Gastroenterology	☐	Maxillo facial
☐	Orthopedics	☐	Podiatry	☐	General Surgery
☐	Ophthalmology	☐	Pain Management	☐	Urology
☐	Other (describe)				

Primary Purpose of the Facility

7. The Certificate of Need Program must understand how a facility operates in order to determine the facility's primary purpose. Typically, governance documents can aid the department in this understanding. These could be in the form of operating agreements, shareholder agreements, or corporate governing documents. Provide any documentation that could aid in this understanding.

8. A facility that receives more than 50% of their income or 50% of their visits from surgeries is subject to CN requirements. In order to determine if your project is subject to CN review, please provide the current (existing facility) and proposed (new facility) percentages of income and visits for clinical and surgical services. Include all assumptions used to determine the percentages provided.

This site's revenue	**Most recent full year of operation** **Year:** 2020	**Projected first full year of operation after the proposed changes** **Year:** _____
Total revenue for clinical services	< 50%	
Total revenue for surgical services	> 50%	
Total revenue	100%	

This site's patient visits	**Most recent full year of operation** **Year:** 2020	**Projected first full year of operation after the proposed changes** **Year:** _____
Total clinical patient visits	≤ 75%	
Total surgical patient visits	≤ 25%	
Total patient visits	100%	